DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G123	A. BUILDING _____ B. WING _____	R-C 10/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	431 53RD STREET, SE WASHINGTON, DC 20019

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{W 000}	INITIAL COMMENTS On October 7, 2009, HRLA received an e-mail from DC Health Resources Partnership, a consultant with Department on Disability Services (DDS). The e-mail documented concerns related to the health and safety of a client residing in the facility. A nurse with the DC Health Resources Partnership (DCHRP) alleged observing systemic deficient practices as specified below: 1. There was no Licensed Practical Nurse (LPN) or Registered Nurse (RN) in the home between 7:00 a.m. and 7:30 a.m. The LPN scheduled to pass medications arrived some time after 8:00 a.m. All scheduled medication passes were late; 2. A client, that was an insulin dependent diabetic, had been given her breakfast without having her blood sugar measured. The LPN checked the client's blood sugar, without the availability of a lancet and the client's blood sugar reading was 127. The primary care physician was notified and ordered that the morning insulin be held; 3. There were no lancets available in the home to perform blood sugar finger sticks. 4. There was a noted discrepancy in one client's medical record between the written physician's order and medication administration record. Due to the nature of the complaint and the facility's status of being in immediate jeopardy (identified on September 30, 2009) surveyors from the State Survey Agency (SA) initiated an onsite investigation on October 7, 2009. During the investigation, concerns were identified that revealed the facility had not enacted sufficient	{W 000}	Received 11/18/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/18/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 000}	Continued From page 1 systems to remove the Immediate jeopardy and therefore, clients' health and safety continued to be at risk. On October 13, 2009, the SA received an allegation of compliance indicating that the immediate jeopardy had been removed. Observation and interviews on October 14, 2009, and October 15, 2009, however, revealed continued deficient practices existed related to the health and safety of the clients and the immediate jeopardy remained in effect. On October 16, 2009, the facility removed the immediate jeopardy by taking immediate and aggressive actions to remedy the problems as evidenced by the following: a. LPN #1 was removed from work schedule and was scheduled to be terminated by October 19, 2009; b. RN #1 was removed from the work schedule pending further corrective action; c. The facility indicated that corrective actions would be implemented to address the DON's failure to supervise and provide adequate oversight of nursing care services. The findings of the survey were based on observations in the group home, interviews with the facility's management, nursing and direct care staff and the review of records, including unusual incident reports, investigation reports and administrative records. Three clients with various disabilities were selected from a residential population of six females. While the facility implemented practices to	{W 000}		

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{W 000}	Continued From page 2 address the immediate jeopardy, condition level deficiencies remained in the domain of Governing Body and Health Care Services.	{W 000}		
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility's governing body failed to maintain general operating direction over the facility. [See W104 and W331] The effects of these systemic practices resulted in the governing body's failure to adequately manage the facility in a manner that would ensure each client's health and safety. [See also W318]	{W 102}	**W102** **This Condition will be met as evidenced by:** Reference responses to W104 and W331.	11-18-09 ongoing
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body exercised general policy and operational direction over the facility, except in the following areas for three of three clients residing in the facility. (Clients #4, #5, and #6). The findings include:	{W 104}	**W104** **This Standard will be met as evidenced by:** 1. Cross reference responses to W102 2. Reference response to W149 3. Reference response to W192. 4. Reference response to W331.	11-18-09 ongoing

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{W 104}	Continued From page 3 On October 13, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited during the October 1, 2009. to the Department of Health. On October 13, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 1, 2009 survey. On October 1, 2009, the facility was cited for implementing policies that ensure the health and safety of the clients residing in the facility. According to the POC, the facility documented that it would ensure physicians's orders were signed and dated within 24 hours, ensure staff would receive training on medication administration policy, and mealtime protocols. 1. Cross Reference to W102. The governing body failed to adequately govern the facility in a manner that would ensure the clients's health and safety, for three of the six clients residing in the facility. 2. Cross Reference to W149. The governing body failed to ensure telephone orders were signed and dated within the 24 hour period, for three of the six clients residing in the facility. 3. Cross Reference to W192. The governing body failed to ensure staff were trained to transcribe orders correctly and failed to ensure mealtime protocols were implemented , for two of the six clients residing in the facility 4. Cross reference to W331. The governing body failed to ensure nursing services in accordance with each client's needs, for three of the six clients residing in the facility.	{W 104}		
{W 114}	483.410(c)(4) CLIENT RECORDS	{W 114}	W114 This Standard will be met as evidenced by: The Physician has been requested to ensure that all orders and entries into the individuals record be signed and dated. The RN assigned to the home will monitor physician orders and follow-up with the PCP when concerns arise. The Director of Nursing will also conduct periodic reviews to further ensure compliance in this area.	11.18.09 ongoing

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{W 114}	Continued From page 4 Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all entries in clients' records were signed, for one of the three clients included in the sample. (Client #1) The findings include: Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 PM revealed Client #1 had several telephone orders that had been signed but not dated by the facility's Primary Care Physician (PCP) as documented below: On August 31, 2009 at 5 p.m. the PCP ordered via telephone the client to return to her day program and an illness; On September 1, 2009 at 3 p.m. the PCP ordered via telephone to discontinue Peptamen DT @ 40 cc/hr x 10 hours from 7 p.m. until 5 a.m.; and On September 1, 2009 at 3 p.m. PCP ordered via telephone that the client Start Peptamen DT @ 50 cc 1 hour x 10 hours from 7 p.m. until 5 a.m. Interview with the Register Nurse on September 30, 2009 failed to provide an explanation as to why the physician had not dated the orders.	{W 114}		
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written	{W 149}		

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{W 149}	Continued From page 5 policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure telephone orders were signed and dated within the 24 hour period, for three of the six clients residing in the facility. (Clients #4, #5, and #6) The finding includes: On October 13, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 1, 2009 survey. On October 1, 2009, the facility was cited for implementing policies that ensure the health and safety of the clients residing in the facility. According to the POC, the facility documented that it would ensure physicians's orders were signed and dated within 24 hours. 1. The facility failed to have a policy to ensure that physician's telephone orders were signed and dated within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13]. a. Review of Client #5's medical record on October 7, 2009, at approximately 6:15 p.m., revealed a telephone orders dated September 29, 2009. According to the orders, the client was prescribed Debrox five drops to both ears, twice a day for five days. Further review of the telephone order revealed no evidence that the order was signed by the primary care physician (PCP). Interview with the registered nurse (RN) on October 7, 2009 at approximately 7:00 p.m. indicated that telephone orders should be signed	{W 149}	W149 **This Standard will be met as evidenced by:** An interim policy was written to address timely signatures and dates within the 24 hour period. Implementation of the policy is monitored by the RN and the LPN assigned to the home. In accordance to the policy the LPN must immediately notify the RN should any delays or problems arise. The policy is currently under review to ensure a that a viable back up plan is included in the process to prevent lapses or delays. All staff will receive training on the final policy once it has been reviewed and approved by the Governing Body.	10.16.09 ongoing

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{W 149}	Continued From page 6 within 24 hours by the PCP. b. Review of Client #4's medical records revealed a telephone orders dated September 19, 2009. The order read, "Cleanse scratch on the forehead with peroxide, apply Neosporin ointment every shift until healed." Further review of the telephone order revealed no evidence that the order was signed or dated by the PCP. Interview with the registered nurse (RN) on October 7, 2009 at approximately 2:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. c. Review of Client #4's medical record on October 14, 2009 at approximately 10:00 a.m., revealed a telephone orders dated October 8, 2009 at approximately 3:15 p.m. According to the orders, the client was prescribed Fosamax 70 mg, one tab, by mouth, every week on Wednesday for osteoporosis. Further review of the telephone order revealed no evidence that the order was signed by the primary care physician (PCP). Interview with the registered nurse (RN) on October 8, 2009 at approximately 4:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. d. Review of Client #4's medical record on October 14, 2009 at approximately 10:00 a.m., revealed a telephone orders dated October 8, 2009 at approximately 3:15 p.m. The order read discontinue 17 units Lantus subcutaneously (SQ) at bedtime for diabetes mellitus; Given Lantus 10 units SQ at bedtime for diabetes mellitus; and discontinue 1/2 diet pudding at bedtime; and give 4 ounces apple juice and one graham cracker. Further review of the telephone order revealed no evidence that the order was signed by the primary	{W 149}		

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{W 149}	Continued From page 7 care physician (PCP). Interview with the registered nurse (RN) on October 10, 2009 at approximately 4:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. e. Review of Client #4's physician orders sheet on October 7, 2009 at approximately 1:45 p.m., revealed a telephone orders that had been signed but not dated by the facility's PCP as documented below: - On September 9, 2009 at 6:00 p.m., the PCP ordered via telephone, an X-ray to last toes (4th and 5th) left foot for toe discoloration. f. Review of Client #6's physician orders sheet on October 8, 2009 at 3:45 p.m., revealed several telephone orders that had been signed but not dated by the facility's PCP as documented below: - On May 17, 2009 at 7:00 p.m., the PCP ordered via telephone, to discontinue Tylenol 650 mg PRN for temperature greater than 100. Start Tylenol 650 mg by mouth every four hours for pain or temperature greater than 100 degree Fahrenheit, PRN - On May 18, 2009 at 1:00 p.m., the PCP ordered via telephone, Augmentin 500 mg by mouth, twice a day for 15 days. Keep patient from picking left 3rd finger. Bactroban ointment to finger, three times a day until healed, clean with normal saline. Based on interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of seven of seven clients residing in the facility. (Clients #1, #2, #3,	{W 149}		

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{W 149}	Continued From page 8 #4, #5, #6, and #7) The findings include: The facility failed to have a policy to ensure that physician's telephone orders were signed within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13]. Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 p.m. revealed Client #1 had several telephone orders that had not been signed by the facility's Primary Care Physician (PCP) within twenty- four (24) hours as required by local regulation: a. September 9, 2009 at 8 p.m. -Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days; -Cleanse stomach stoma with NSS, pat dry apply Bacitracin 500 units to G-tube site twice daily, cover with dressing. b. September 13, 2009 at 3:30 p.m. -Bactrim DS via G-tube BID x 10 days for MRSA. Monitor vital signs twice daily x 10 days. D/C Keflex-bacteria is resistant to Keflex. c. September 14, 2009 at 3:00 p.m. -D/C Bactrim, start Avelox 400 mg QD x 7 days. d. September 23, 2009 at 6:30 p.m. -Start Peptamen DT @ 50 cc 1 hr x 10 hours from 7 p.m. to 5 a.m. D/C Osmolite 1.2 CAL from	{W 149}		

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{W 149}	Continued From page 9 8 p.m. to 6 a.m. @ 30 cc/hrs x 10 hrs. Interview with the Director of Nursing on October 1, 2009 acknowledged that the aforementioned telephone orders from the PCP had not been signed by the PCP within twenty-four hours.	{W 149}	W192 This Standard will be met as evidenced by: 1. Reference response to W331. 2. The LPN staff will receive additional training on adherence to usage of adaptive equipment during medication pass. The RN will also monitor medication administration passes and take corrective actions as needed to include but not limited to; training, disciplinary actions, purchasing /acquiring equipment as needed. 3. Disciplinary action was implemented for the staff who failed to implement client #5's liquids as ordered. The Home Manager, and LPN staff assigned to the home continue to conduct routine mealtime observations and provide feedback and direction to the staff on a regular basis.	11.18.09 ongoing
{W 192}	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff were trained to transcribe orders correctly and failed to ensure mealtime protocols were implemented , for two of the six clients residing in the facility. (Clients #4 and #5) The findings include: On October 13, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 1, 2009 survey. According to the POC, the facility documented that it would receive additional training on ensuring consistency with mealtime protocols in accordance to physician orders, and nutrition recommendations. 1. Cross Refer to W331. The facility failed to ensure nursing staff were effectively trained to transcribe and review physician's orders accurately. 2. The facility's medication nurse failed to use the appropriate adaptive feeding equipment during	{W 192}		

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{W 192}	Continued From page 10 medication administration for Client #5. During medication administration observation on October 14, 2009, at 9:15 p.m., the Licensed Practical Nurse (LPN) was observed administering Client #5 her medications using a regular cup. The liquid was observed to spill from the client's mouth. During dinner observations on October 14, 2009, at 5:35 p.m., the direct care staff was observed assisting the client with drinking using a spout cup. Further observations revealed no spillage during the meal. Interview with the direct care staff on October 14, 2009, during the meal revealed that the client required a spout cup during feeding to reduce spillage. Review of the Client #5's feeding protocol dated April 22, 2009, verified the staff's interview by revealing the client should be fed with an adaptive spout cup to reduce spillage. 3. The direct care staff failed to demonstrate competency in implementing the clients feeding protocols, for Clients #5 and Client #4. a. Observations during dinner on October 7, 2009, beginning at 6:30 p.m., revealed the direct care staff was observed feeding Client #5 her dinner. The meal consisted of pureed turkey chops, rice, greens, pears and regular thin liquid juice. Later during the meal observations at 7:38 p.m., Client #5 was heard gurgling. The direct care staff was observed placing the client's cup onto the table after assisting the client with drinking. The liquid being fed to the client was thin, the texture of water. The staff was questioned about the consistency of Client #5's liquids. The direct care care stated that the liquids should be nectar consistency.	{W 192}	4. All staff received competency training on transcription of physician orders, assessing weights and administering g-tube feedings on October 12, 2009. The RN continues to monitor and provide direction to the LPN assigned to the home. 1. Reference response to #4. 2. Reference response to #4. The Director of Nursing will continue to forward copies of all completed trainings to the group home site for filing. The Director of Nursing will also maintain a copy as a back-up. 3. Cross reference response to W331(#1.a.b.c.). The nurses have participated in training on transcription of physician orders and procedures to properly calculate fluid restrictions. The Director of Nursing will continue to	

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(W 192)	Continued From page 11 Review of Client #5's feeding protocol dated April 22, 2009, revealed that all liquids were ordered to be thickened to nectar consistency. The client's current physician orders dated October 2009, confirmed the nectar thickened liquid consistency. It should be noted that the review of the facility's training records on October 8, 2009, at approximately 3:00 p.m., revealed that the direct care staff received training on Client #5's feeding protocol on August 28, 2009; however the direct care staff failed to provide the proper nectar thickened liquid consistency to Client #5. 4. On October 7, 2009 at 6:33 p.m., Client #4 was observed eating dinner. The meal consisted of shredded chicken, sliced carrots and rice. Interview with the direct care staff, during the meal, indicated that the client receives a chopped texture diet. Review of Client #4's mealtime protocol dated January 22, 2009, revealed a chopped texture diet. Further review of the client's current physician orders dated October 2009, confirmed the mealtime protocol. Review of the facility's training records on October 8, 2009, at approximately 3:00 p.m., revealed staff had received training on Client #4's diet and feeding protocol on August 28, 2009. However the direct care staff failed to provide the proper diet consistency to Client #4 during meals. Based on interview and record review, the facility failed to ensure that each employee providing nursing services was trained to competently	(W 192)	schedule and coordinate training with incoming nursing staff and provided on-going training thereafter. Corrective actions will be taken for employees who fail to consistently participate and meet training requirements.	

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OMB NO. 0938-0391

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{W 192}	Continued From page 12 transcribe orders, assess weights, and, administer G-tube feedings. This failure posed likely harm to all clients' health. The findings include: 1. The facility's nursing services failed to ensure that each licensed staff had received training on procedures to accurately measure the clients' body weight. Client #1 had a decrease in her body weight from 88.7 pounds in March 2009 to 62 pounds in April 2009. The client, as of September 29, 2009, had lost an additional pound, placing her below her Healthy Weight Range (HWR 62-82 lbs). On September 30, 2009, beginning at 8:45 p.m., interviews were conducted with the RN supervisor and Director of Nursing to ascertain more information. According to RN Supervisor, weight variations had been documented for several of the clients residing in the facility and it was suspected that weight's had not been completed and/or measured accurately in previous months. The RN supervisor further indicated that the weighing policy had been revised to ensure accuracy of weights and to identify measures to enact if warranted. The Director of Nursing (DON) revealed that the Supervisory nursing staff had provided training to the nursing staff on the correct policy and procedure for measuring clients' body weights, to include calibration of the scale to ensure that the scale was accurately measuring weight. Earlier interview with the LPN and the QMRP on September 30, 2009 revealed that a new scale, recommended by the Interdisciplinary Team (IDT)	{W 192}		

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{W 192}	Continued From page 13 had been ordered, but had not been received. The QMRP indicated that the scale currently being used in the facility had been calibrated and was accurate. The QMRP also indicated that all nurses had been trained in its use. When the LPN on duty was asked to demonstrate the weighting techniques, she failed to following the weighing protocol that required the scale to be calibrated prior to placing the individual on the scale. The QMRP acknowledged that the LPN failed to following the weighing protocol. The RN was asked to provide evidenced that all nurses had been trained to weigh clients using the chair scale. The RN could not provide any documentation of training. 2. Similarly, interview with the nurses indicated that the Supervisory RN and Director of Nursing had trained nursing staff on tube feeding procedures for Client #1. This reportedly addressed changes in the client's tube feeding schedule. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on tube feeding procedures. No additional information was provided; therefore, a chronological history of nurse training on the facility's weighing and G-Tube feeding protocol could not be verified. It should be noted that this is a repeat deficiency. 3. Cross Refer to W331 (#1a.b.c). The facility failed to ensure nursing staff were effectively trained to transcribe physician's orders accurately.	{W 192}		

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{W 192}	Continued From page 14 a. Review of Client #1's record on September 30, 2009 evidenced physician orders (dated September 1, 2009, and September 9, 2009, September 23, 2009 September 29, 2009) that were transcribed inaccurately, which could likely posed a risk to the clients' health and safety. According to the Director of Nursing (DON), the supervisory nursing staff had provided training to all nursing staff on and after the August 25, 2009, on the importance of transcribing physician orders' accurately. Review of the in-service training records, however, failed to show evidence of said training on transcribing of all physicians' orders. The DON acknowledged that the physician's orders were transcribed incorrectly and that nursing in-service training session were ineffective. 3. Cross-refer to W331.6 The facility's nursing services failed to ensure that each licensed staff had received training on procedures to properly calculate fluid restrictions for Client #2 and #3, as ordered by the Primary Care Physician (PCP). Review of Clients #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Client #2's physician orders verified the client was prescribed a fluid restriction of 880 cc	{W 192}		

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(W 192)	Continued From page 15 of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the client ' s total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Client #3's physician ' s orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the client ' s total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records	(W 192)		

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{W 192}	Continued From page 16 failed to show evidence of said training on fluid intake/restrictions.	{W 192}		
{W 318}	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; the facility failed to assure that all drugs are administered in compliance with the physician's orders [Refer to W368]; and the facility failed to ensure that nurses were were competent to provide nursing services [Refer to W192]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services. Based on interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; the facility's registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis [Refer to W336]; the facility failed to assure	{W 318}	W318 This Condition will be met as evidenced by: Reference responses to W331, W368, and W192. The Medical Director in coordination with the DON will continue to evaluate and assess and implement policies and protocols to ensure that health care practices, to include; monitoring, identifying services in accordance with clients needs, medications administered, compliance with the physician's orders, competency and systemic practices analyzed and addressed to ensure that health care services are met.	11.18.09 DNgoing

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{W 318}	Continued From page 17 that all drugs are administered in compliance with the physician's orders [Refer to W368]; the facility's nurse failed to store drugs under proper conditions of security, during the medication administration [Refer to W381]; and the facility failed to ensure that nurses were were competent to provide nursing services [Refer to W192]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	{W 318}		
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing serves in accordance with each client's needs, for three of the six clients residing in the facility. (Clients #4, #5, and #6) The findings include: October 1, 2009, the facility was cited for failure to ensure employees providing nursing services, were trained to competently transcribe orders, assess weights, calculate fluid restriction and administer G-tube feedings. On October 13, 2009, the facility submitted a Plan of Correction (POC) which stated that all nurses in the home would receive additional training on appropriate transcribing of physicians' orders, adherence to the medication administration policy, documentation and communication between the primary care physician (PCP), ensure consistency with mealtime protocols in accordance to	{W 331}	W331 This Standard will be met as evidenced by: 1. Cross reference responses to W192 2. Cross reference responses to W436. 3. Cross reference response to W192 (2) 4. Cross reference response to W192 (3)	11/18/09

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{W 331}	Continued From page 18 physician orders and addressing nutrition recommendations. 1. Cross Refer to W192. The facility failed to ensure nursing staff were effectively trained to transcribe and review physician's orders accurately. (Client #4 and Client #5) 2. Cross Refer to W436. The facility nurses failed to follow-up on medical consultation order for custom molded shoes for Client #4. 3. The facility's medication nurse failed to use the appropriate adaptive feeding equipment during medication administration for Client #5. During medication administration observation on October 14, 2009 at 9:15 p.m., the Licensed Practical Nurse (LPN) was observed administering Client #5 her medications using a regular cup. The liquid was observed to spill from the client's mouth. During dinner observations on October 14, 2009 at 6:35 p.m., the direct care staff was observed assisting the client with drinking using a spout cup. Further observations revealed no spillage during the meal. Interview with the direct care staff on October 14, 2009, during the meal revealed that the client required a spout cup during feeding to reduce spillage. Review of the Client #5's feeding protocol dated April 22, 2009, verified the staff's interview by revealing the client should be fed with an adaptive spout cup to reduce spillage. 4. During dinner observations on October 7, 2009 at 6:33 p.m., Client #4 was observed eating. The meal consisted of shredded chicken, sliced carrots and rice. Interview with the direct care staff, during the meal, indicated that the client	{W 331}	W331, continued... 1-6 The Director of Nursing implemented disciplinary action for the RN who failed to transcribe telephone orders when given. The Director of Nursing also provided additional training for all RN staff to include but not limited to; ongoing supervision requirements, timely assessments/follow-up, documentation and communications with the PCP. The RN will conduct assessments at discharge for each individual and document in the record. All physician orders are to be reviewed by the RN for accuracy with regular reviews and monitoring by the Director of Nursing to further ensure compliance with the standards. The RN in coordination with the Director of Nursing will monitor implementation of the POS, provide training on g-tube feedings, and medication administration to include competency reviews. Client #1 no longer resides in the home.	10.21.09 ongoing

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{W 331}	Continued From page 19 receives a chopped texture diet. Review of Client #4's mealtime protocol dated January 22, 2009, revealed a chopped texture diet. Further review of the client's current physician orders dated October 2009, confirmed the mealtime protocol. Review of the facility's training records on October 8, 2009, at approximately 3:00 p.m., revealed that the staff received training on Client #4's diet and feeding protocol on August 28, 2009. However the direct care staff failed to provide the proper diet consistency to Client #4. Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for three of three clients in the sample. (Client #1, Client #2 and Client #3) The findings include: 1. The nursing staff failed to transcribe Client #1's physician's orders accurately, which could likely pose a risk to the clients' health as evidence by the following: a. Interview with the nursing supervisor on September 30, 2009 at 8:45 a.m. revealed that Client #1 was hospitalized from September 15, 2009 through September 23, 2009 for elevated temperature and PEG tube infection. Further interview revealed that the RN supervisor had contacted the Primary Care Physician (PCP) upon the client's return to the group home and received an order to "resume all previous orders".	{W 331}		

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{W 331}	Continued From page 20 Review of Client #1's record at approximately 9:00 a.m. revealed a readmission order that indicated "orders valid for 120 days. Resuming all previous orders, T.O. (telephone order) PCP reviewed by RN supervisor 9/23/09." Additional handwritten orders, dated September 23, 2009 were discovered in the nurses' station by Licensed Practical Nurse (LPN) #1 that were more specific and identified discharge orders that were not signed by the transcriber or the physician. The Register Nurse (RN) stated that she received the telephone orders from the PCP between 4 p.m. and 5 p.m. and acknowledged that she had not transcribed the telephone order from the PCP when it was given to her. On 9/30/09 at approximately 3:30 p.m. contact was made with the PCP via phone which verified that he had given the RN supervisor a telephone order to resume all previous orders. At the time of the investigation, the facility's RN failed to transcribe telephone orders as given. b. Review of a physician order dated September 1, 2009 at approximately 8:55 am revealed the client was to receive Dilantin chewable tablets (U-D 50 mg tablets), 2 tablets crushed via G tube everyday at 7 a.m. for seizure disorder, hold tube feeding for 1 hour before and after administration of Phenytoin. Review of the corresponding Medication Administration Record at 9:00 a.m. revealed that the client was receiving her G-tube feeding from 6 p.m. to 6 a.m. Review of the Medication Administration Record (MAR), however, revealed that the client was being administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 AM. In an interview with the RN Supervisor at 9:05 a.m. , she	{W 331}		

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{W 331}	Continued From page 21 acknowledge that Client #1 was administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 a.m. c. Review of the Client #1's records at approximately 10:45 a.m. revealed a physician order, dated September 1, 2009. According to the physician's order, the client was prescribed Dilantin 2 tabs (100 mg) crushed via G-tube for seizure disorder. Review of the September 2009 MAR; however, documented the transcription of the order on September 29, 2009 as Dilantin (chewable)U-D 50 mg tab, 20 tablets (100 mg) crushed via G-tube for seizure disorder. The MAR was signed by a nurse on September 30, 2009 indicating the order for 20 tablets had been administered. Interview with the RN supervisor at approximately 10:46 a.m. acknowledge the order for 20 tablets of Dilantin crushed via G-tube for seizure disorder had been transcribed instead of Dilantin (chewable) U-D 50 mg tab, 2 tablets (100 mg) crushed via G-tube everyday . 2. The nursing staff failed to calculate Client #1's G-Tube flushes in accordance with physician orders which could likely pose a risk to the clients' health and safety as evidence by: Review of the Client #1's medical record revealed a physician order, dated September 1, 2009. According to the order, the client was to receive water flushes (via G-tube) prior to medications, between, and after medications. The order specified that her G-tube was to be flushed with 20 cc of water both prior to and after medications, and a 5 ml flush was to occur between medications. The review of the corresponding Fluid Intake Monitoring Sheet for G-Tube, dated September, 2009, revealed that	{W 331}		

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{W 331}	Continued From page 22 the nurses documented completing 70 cc of water flushes, which did not correspond to the number of times medication was administered. The Director of Nursing (DON) could not explain the discrepancy. Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility nursing staff were completed the flushes incorrectly. 3. The nursing staff failed to clarify Client #1's physician telephone orders accurately, which could likely pose a risk to the clients' health and safety as evidence by: a. Review of Client #1's records revealed a telephone order, dated September 29, 2009. According to the client's physician's telephone order, the client was prescribed " Osmolyte 1.2 at 30 cc/hr, 1 can every 6 hours from 6 a.m. - 6 p.m. (total of 3 cans per day) with 2 packages of Procel a day or 909 kcals, 49 gm protein, 580 ml of water a day " . The nurse failed to clarify how to administer three cans of feedings with the restriction of one can every six hours during her 12 hour continuous feed. Furthermore, the nurse failed to identify the exact type and amount of Protein supplement to be administered with the client ' s continuous feed. It should be noted that interview with the Director of Nursing at approximately 5:30 p.m. acknowledged that three cans of the Osmolyte 1.2 could not be administered in total at the prescribed rate within the specified 12 hour feeding cycle. b. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the client had a "Primary Diagnosis:	{W 331}		

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(W 331)	Continued From page 23 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days. Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. 4. The facility nurses failed to administer Client #1's prescribed G-tube feeding at scheduled time. On September 30, 2009 at approximately 6:00 p.m. Client #1 was observed laying in her bed, at approximately a 30 degree angle and was not receiving her 6 p.m. continuos G-tube feeding. At approximately 6:15 p.m., the Department of Health surveyors informed the Director of Residential Services that Client #1's prescribed feeding had not been administered at the prescribed time. At approximately 6:35 PM the LPN #2 was observed administering 2 cans Osmolite 1.2 cal at 30 cc/hr. 5. The facility nurses failed to update Client #1's Health Management Care Plan (HMCP). a. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 on September 30, 2009 revealed that the client had "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at	(W 331)		

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OMB NO. 0938-0391

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(W 331)	Continued From page 24 approximately 1:00 a.m. revealed Client #1's HMCP did not updated to include the new diagnoses of Abscess/cellulitis-skin and postoperative infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:15 a.m. acknowledged that the HMCP had not been updated to include the September 9, 2009 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection. b. Review of the hospital discharge summary report dated September 22, 2009 revealed that Client #1 was hospitalized from September 15, 2009 to September 23, 2009 for treatment of an elevated temperature and PEG tube infection. Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:05 a.m. revealed Client #1's HMCP was not updated to include the treatment for elevated temperature and PEG tube infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:35 a.m. acknowledged that the HMCP had not been updated to include the hospitalization for elevated temperature and PEG tube infection. There was no evidence that the HMCP had been updated since August 25, 2009. 6. The facility nurses failed to accurately implement Client #2 and #3's fluid restriction. Review of Clients #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received.	(W 331)		

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{W 331}	Continued From page 25 a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Client #2's physician orders verified the client was prescribed a fluid restriction of 880 cc of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the client ' s total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Client #3's physician ' s orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the client's total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on	{W 331}		

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{W 331}	Continued From page 26 September 30, 2009 at approximately 5:10 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. There was no evidence that fluid restriction requirements were implemented as prescribed.	{W 331}		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis, for two of the six clients residing in the facility. (Clients #4 and #5) The findings include: 1. Review of Client #4's medical record on October 7, 2009, at approximately 4:00 p.m., revealed an annual nursing assessment dated January 17, 2009. Further review of the client's record revealed there was no quarterly assessment in the record after the annual nursing assessment. Interview with the RN on October 7, 2009, at approximately 4:45 p.m., revealed that direct physical examinations should be completed every quarter (3 months). 2. Review of Client #5's medical record on	W 336	W336 **This Standard will be met as evidenced by:** 1. The quarterly nursing assessment was completed for client #4. 2. Client #5's annual nursing assessment has been completed. The RN assigned to each home will maintain a schedule of dates when quarterly reports and assessments are due. Schedules of completion dates will be performed within the month in which the end of the quarter falls. The Director of Nursing or designated consultants will review the records on a regular basis to ensure ongoing compliance. The Director of Nursing will review all Annual Nursing Assessments for new and incoming RN's to ensure that documents are completed in accordance to standard.	11.18.09 ongoing

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W 336	Continued From page 27 October 7, 2009, at approximately 7:00 p.m., revealed an annual nursing assessment dated September 27, 2009, however, the assessment was incomplete. The assessment had four of the seven pages completed. Interview with the RN on October 7, 2009, at approximately 5:00 p.m., confirmed the assessment was incomplete.	W 336	W368 **This Standard will be met as evidenced by:** 1. Disciplinary action was taken against the LPN staff who failed to administer medications in compliance with the physician orders. (#3,#4, and #6).The RN will review the records on a regular basis, address discrepancies and ensure that that there is documented evidence reflected in the record that the primary care physician and Medical Director been informed and provided direction as needed. 2. Reference response to #1. The LPN staff are expected to review the MAR's q shift and reconcile as needed. In addition, the RN will review MAR's and physician orders for accuracy. Client #4's Head and Shoulders is currently being administered as prescribed.	11.18.09 ongoing
{W 368}	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physicians ' orders, for three of the six clients residing in the facility. (Clients #3, #4 and #6) The findings include: 1. The nursing staff failed to administer Client #4's order as prescribed which posed a likely risk to the client's health and safety. a. Observation of the evening medication administration on October 7, 2009 at 6:45 p.m. revealed Client #4 was administered Novolog insulin, 5 units, Glucophage 1000 mg, and Os-Cal 200 mg. Review of the corresponding Medication Administration Record (MAR) and October 2009 physicians orders on October 7, 2009, revealed the client was prescribed Novolog insulin 5 units before dinner on October 7, 2009. A face to face interview with LPN #1on October 7, 2009 immediately following the medication	{W 368}		

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{W 368}	Continued From page 28 observation revealed that she gave Novolog insulin 4 units previously ordered on February 20, 2009. When LPN#1 was asked by the surveyor why she did not give the 5 units as ordered, she stated " I was not aware of the new order". Further observation on October 7, 2009 at approximately 6:00 p.m. revealed the nurse changed on the MAR to indicate that Novolog insulin 5 units would start on October 8, 2009 and not on October 7, 2009 as ordered by the physician. There was no documented evidence in the record that the nurse made the physician aware that the order did not start on October 7, 2009 as prescribed. b. Review of Client #4's record on October 8, 2009 at approximately 11:00 a.m. revealed a telephone order dated July 21, 2009, at 4:20 p.m. The order the client was to receive which documented, "Debrox ear drops 6.5% 5 drops to both ears twice daily for five days (which should equal to 10 doses of medication) for wax removal." Further review of the clients record revealed a MAR for July 2009 that documented that the facility's nursing staff failed to administer all ten doses of Debrox as ordered. According to the record, Client #4 received nine of the ten doses ordered. c. A record of Client #4's record on October 8, 2009, at approximately 11:30 a.m. revealed a telephone order for Debrox dated August 4, 2009 at 4:30 p.m. According to the order, the client was to receive "Debrox optic drops 6.5% instill 4 drops in left ear twice a day for 5 days (which	{W 368}	W368, continued... 3. Reference responses to #1 and #2. 1 and 2. Client #1 no longer resides in the home. The staff assigned to client#1 received disciplinary action for failing to document and provide follow-up in accordance to policy and procedures and nursing standards of practice. Additional training competency based training was provided to the LPN staff assigned to the home to include but not limited to; medication administration, and compliance physician orders, transcribing orders. Reference responses to W331 and W192.	10.1604 onepm

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{W 368}	Continued From page 29 should equal to 10 doses of medication)." Further review of record revealed a MAR for August 2009 which documented that the facility nursing staff failed to administer the ten doses of Debrox ordered. Client #4 received nine of the ten doses ordered. d. Review of Client #4's record on October 8, 2009,at approximately 3:00 p.m. revealed an order date January 30, 2009 for "Head and Shoulders daily." Further review of Client #4's record revealed MAR's from February 2009 through October 2009 which documented that Client #4 had treatments of the Head and Shoulders three times a week (which was an ordered dated from February 23, 2004). During a face to face interview with LPN#2 on October 8, 2009, at approximately 4:55 p.m. revealed that Client #4 had a dermatology consult in January 2009 however, she was unable to locate the report at the time of the interview. She acknowledged that Client #4 was not receiving the Head and Shoulder treatments daily as prescribed. 2. During the entrance conference on October 14, 2009, at 1:33 p.m., the registered nurse (RN) indicated that Client #3 received a new physician order for eye drops. Review of Client #3's medical records on October 14, 2009 at 2:30 p.m. revealed a telephone order for Gentamicin eye drops, four times a day to both eyes, dated October 7, 2009 at 5:00 p.m. According to the MAR, the client received Gentamicin (generic eye drops) sulfate 30 mg/ml, two drops in each eye	{W 368}		

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{W 368}	Continued From page 30 twice a day, beginning October 8, 2009 through October 14, 2009. Interview with the RN on October 14, 2009 at approximately 3:00 p.m., confirmed the client received two eye drops twice a day. There was no evidence that the facility's medication nurse administered Client #3's eye drops as ordered (four times a day). 3. Review of Client #6's medical record on October 8, 2009, at 4:15 p.m., revealed a telephone order dated May 18, 2009. The order was for Augmentin 500 mg by mouth, twice a day for 15 days (30 doses). Review of the client's medication administration records (MARs) on October 8, 2009 at approximately 4:30 p.m. revealed that the client received the medication beginning on May 18, 2009, during the evening medication administration through May 31, 2009. Further review of the MARs revealed that the client received 27 doses of the prescribed medication. Additionally the registered nurse (RN) was interviewed on October 8, 2009 at approximately 5:10 p.m., to ascertain information regarding the location of the June 2009 MAR. The RN could did not retrieve the June 2009 MARs. By the end of the survey, the RN failed to locate and provide the June 2009 MAR for review. There was no evidence that Client #6 received the prescribed doses of the antibiotics. Based on interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for one of	{W 368}		

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{W 368}	Continued From page 31 three clients included in the sample. (Client # 1) The finding includes: 1. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated August 25, 2009 at 12 noon revealed that she was diagnosed with a Furuncle (boil). Further review of the medical record revealed a physician order, dated August 25, 2009. According to the physician ' s order, Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day for 7 days (for upper lip abscess). Although the medication was prescribed for 7 days, the August 2009 MAR indicated that Bactrim OS Suspension 20 ml was initially administered on August 26, 2009 at a.m. and discontinued on September 2, 2009 at 7 p.m. (8 days). Interview with the RN Supervisor at approximately 12:15 p.m. acknowledged that Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day. Additionally, the RN verified that the medication had been administered for 8 days. 2. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the client had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended "Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days." Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess.	{W 368}		

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{W 368}	Continued From page 32 Review of September 2009 MAR on September 30, 2009 at approximately at 1:00 PM revealed Keflex 250 mg (5 ml suspension) 10 ml Q 6 hours x 10 days was not documented as administered on September 13, 2009 at 6 p.m. Interview with the RN Supervisor at approximately 1:15 p.m. acknowledged that Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs was not documented as administered.	{W 368}		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, the facility's nurse failed to store drugs under the proper conditions of security, during the medication administration, for two of the six clients in the facility. (Clients #4 and #6) The findings include: 1. On October 7, 2009 at 7:41 p.m., the licensed practical nurse (LPN) #1 was observed to leave the medication closet door opened and unlocked while she went to administer Client #4's medication in her bedroom. When the medication closet door was open; the direct care staff, clients, the Director of Residential Services (DRS), and surveyors were in the room while the medications were unsecured. The DRS was informed and acknowledged the unsecured medications at 7:45 p.m.	W 381	W381 **This Standard will be met as evidenced by:** The LPN assigned to the home received disciplinary action for failing to secure the medication closet. The LPN no longer works for the company. The RN will monitor and observe medication administration passes on a routine basis to include proper security of medications.	10/16/09

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W 381	Continued From page 33 2. On October 14, 2009 at 7:58 p.m., LPN #1 was observed to leave the medication closet door opened and unlocked will she went to administer Client #6's medication in their bedroom. When the medication closet door was open; the direct care staff, clients, the Director of Residential Services (DRS), and surveyors were in the room while the medications were unsecured. The DRS was informed and acknowledged the unsecured medications at 8:07 p.m.	W 381		
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to furnish custom molded shoes, for one of the six clients residing in the facility. (Client #4) The finding includes: On October 7, 2009 and October 8, 2009, Client #4 was observed kicking off her sneakers. Interview with the direct care staff during the survey revealed that the client does not like to keep shoes on. Review of Client #4's medical record on October 8, 2009, at 1:45 p.m., revealed a podiatry consult dated September 11, 2009. The consult indicated mild discolorations on the 4th and 5th left toes,	{W 436}		

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{W 436}	Continued From page 34 and ordered custom molded shoes. Interview with the licensed practical nurse on October 8, 2009 at approximately 2:00 p.m. revealed that she was unaware of the physician order; and therefore an appointment for custom shoes hand not been made for the client. After the interview, an appointment was scheduled for custom molded shoes. Based on observation and interview, the facility failed to ensure devices and aids identified by the interdisciplinary team as needed by the client were available for seven of seven clients residing in the facility. (Client #1, #2, #3, #4, #5 #6, and #7) The finding includes: The facility failed to ensure the prescribed scale was available for use. On September 30, 2009 HRLA received an e-mail from DDS that indicated concerns related to the health and safety of the clients residing at the facility. Allegedly, on September 29, 2009 the nurse consultant requested that Client #1 be weighed during the visit and found that the client weighed 61 lbs on the chair scale. This was the scale reportedly used on September 23, 2009 when her weight was calculated at 62 pounds. Interview conducted with the RN Supervisor at 8:45 a.m., confirmed that weight variations had been an agency concern and indicated that a new scale had been ordered. She further stated that	{W 436}	W436 This Standard will be met as evidenced by: As indicted client #4 was seen for evaluation of molded shoes. The new scale has been received and is currently in use at the home. The adaptive equipment policy and procedures is currently being revised to ensure a more timely and efficient tracking process.	11/18/09 Snapin

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	09G123	A. BUILDING _____ B. WING _____	R-C 10/16/2009

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{W 436}	Continued From page 35 the home was currently utilizing the old chair scale, which was observed in the wheelchair bathroom located towards the nursing station. Interview conducted with the Qualified Mental Retardation Professional (QMRP) at approximately 9:30 a.m. revealed that a new scale (Detecto 6475 digital chair scale) was recommended by the Registered Dietitian (RD) on September 1, 2009 and ordered. The new scale would be shipped to the group home on October 2, 2009 and during the interim, the old chair scale would continue to be utilized. Documentation for the new scale ordered, however, was not available for verification at the time of the investigation. Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility had not acquired the new scale.	{W 436}		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement correct infection control procedures to prevent communicable infectious diseases, for one of the six clients residing in the facility. (Client #7) The finding includes: During dinner observations, on October 14, 2009 at 7:35 p.m., Client #7 was observed spitting chewed food onto the floor. The direct care staff	W 455	W455 **This Standard will be met as evidenced by:** Additional staff training has been completed on infection control and maintaining sanitary conditions and use of gloves and hand washing at all times. The Home Manager and nursing staff assigned to the home will continue to monitor infection control practices to ensure ongoing compliance with this standard.	11/18/09 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2009
FORM APPROVED
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W 455	Continued From page 36 was observed wiping the food from the floor with paper towels. The staff was not observed to wear gloves or wash her hands after she wiped up the food from the floor. Although review of the staff in-service training book on October 15, 2009 confirmed that staff had received infection control training on the management of body fluids, the training was ineffective.	W 455		

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(I 000)	INITIAL COMMENTS On October 7, 2009 HRLA received an e-mail from DC Health Resources Partnership consultant with Department on Disability Services (DDS) that indicated concerns related to the health and safety of a Resident residing in the facility. A nurse with the DC Health Resources Partnership (DCHRP) alleged observing systemic deficient practices as specified below: 1. There was no Licensed Practical Nurse (LPN) or Registered Nurse (RN) in the home between 7:00 a.m. and 7:30 a.m. The LPN scheduled to pass medications arrived some time after 8:00 a.m. All scheduled medication passes were late; 2. A resident, that was an insulin dependent diabetic, had been given her breakfast without having her blood sugar measured. The LPN checked the Resident's blood sugar, with the availability of a lancet, knowing that she had been fed breakfast. The Resident's blood sugar read 127. The PCP was notified and ordered that the morning insulin be held; 3. There were no lancets available in the home to perform blood sugar finger sticks. 4. There was a noted discrepancy in one resident's medical record between the written physician's order and medication administration record. Due to the nature of the complaint and the facility's status of being in immediate jeopardy(identified on September 30, 2009) surveyors from the State Survey Agency (SA) initiated an onsite investigation on October 7, 2009. During the investigation, concerns were identified that revealed the facility had not enacted sufficient	(I 000)		

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(I 000)	Continued From page 1 systems to remove the Immediate jeopardy and therefore, Residents' health and safety continued to be at risk. On October 13, 2009 the SA received an allegation of compliance indicating that the Immediate jeopardy had been removed. However, observation and interviews on October 14, 2009 and October 15, 2009 revealed continued deficient practices existed related to the health and safety of the clients and the immediate jeopardy remained in effect. On October 16, 2009, the facility removed the immediate jeopardy by taking immediate and aggressive action to remedy the problems as evidenced by the following: a. LPN #1 was removed from work schedule and was to be scheduled to be terminated by October 19, 2009; b. RN #1 was removed from the work schedule pending further corrective action; c. The facility indicated that corrective would be implemented to address the DON's failure to supervise and provide adequate oversight of nursing care services. The findings of the survey were based on observations in the group home, interviews with the facility's management, nursing and direct care staff and the review of records, including unusual incident reports, investigation reports and administrative records. Three clients with various disabilities were selected from a residential population of six females.	(I 000)		
(I 229)	3510.5(f) STAFF TRAINING	(I 229)		

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(I 229)	Continued From page 2 Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to ensure staff were trained to transcribe orders correctly and failed to ensure mealtime protocols were implemented , for two of the six residents residing in the facility. (Residents #4 and #5) The findings include: On October 13, 2009, the GHMRP submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 1, 2009 survey. According to the POC, the GHMRP documented that it would receive additional training on ensuring consistency with mealtime protocols in accordance to physician orders, and nutrition recommendations. 1. Cross Refer to W331. The GHMRP failed to ensure nursing staff were effectively trained to transcribe and review physician's orders accurately. 2. The GHMRP's medication nurse failed to use the appropriate adaptive feeding equipment during medication administration for Resident #5. During medication administration observation on October 14, 2009, at 9:15 p.m., the Licensed	(I 229)	3510.5 (f) **This Statute will be met as evidenced by:** 1. Cross reference response to W331. 2. Reference responses to W331 and W192. 3. Reference response to W192. 4. Reference response to W192 1. Reference response to W436. 2. Reference response to W192. 3. Cross reference responses to W331 (#1a.,b.c) Also reference responses to W114, W149, W368,W381, W436, and W455.	11.18.09 ORIGINAL

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(I 229)	Continued From page 3 Practical Nurse (LPN) was observed administering Resident #5 her medications using a regular cup. The liquid was observed to spill from the client's mouth. During dinner observations on October 14, 2009, at 5:35 p.m., the direct care staff was observed assisting the client with drinking using a spout cup. Further observations revealed no spillage during the meal. Interview with the direct care staff on October 14, 2009, during the meal indicated that the client required a spout cup during feeding to reduce spillage. Review of the Resident #5's feeding protocol dated April 22, 2009, verified the staff's interview by revealing the resident should be fed with an adaptive spout cup to reduce spillage. 3. The direct care staff failed to demonstrate competency in implementing the residents feeding protocols, for Resident #5 and Resident #4. a. Observations during dinner on October 7, 2009, beginning at 6:30 p.m., revealed the direct care staff was observed feeding Resident #5 her dinner. The meal consisted of pureed turkey chops, rice, greens, pears and regular thin liquid juice. Later during the meal observations at 7:38 p.m., Resident #5 was heard gurgling. The direct care staff was observed placing the client's cup onto the table after assisting the client with drinking. The liquid being fed to the client was thin, the texture of water. The staff was questioned about the consistency of Resident #5's liquids. The direct care care stated that the liquids should be nectar consistency. Review of Resident #5's feeding protocol dated April 22, 2009, revealed that all liquids were ordered to be thickened to nectar consistency.	(I 229)		

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{I 229}	Continued From page 4 The resident's current physician orders dated October 2009, confirmed the nectar thickened liquid consistency. It should be noted that the review of the facility's training records on October 8, 2009, at approximately 3:00 p.m., revealed that the direct care staff received training on Resident #5's feeding protocol on August 28, 2009; however the direct care staff failed to provide the proper nectar thickened liquid consistency to Resident #5. 4. On October 7, 2009 at 6:33 p.m., Resident #4 was observed eating dinner. The meal consisted of shredded chicken, sliced carrots and rice. Interview with the direct care staff, during the meal, indicated that the client receives a chopped texture diet. Review of Resident #4's mealtime protocol dated January 22, 2009, revealed a chopped texture diet. Further review of the resident's current physician orders dated October 2009, confirmed the mealtime protocol. Review of the facility's training records on October 8, 2009, at approximately 3:00 p.m., revealed that the staff received training on Resident #4's diet and feeding protocol on August 28, 2009. However the direct care staff failed to provide the proper diet consistency to Resident #4 during meals. Based on interview and record review, the facility failed to ensure that each employee providing nursing services was trained to competently	{I 229}		

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{I 229}	Continued From page 5 transcribe orders, assess weights, and, administer G-tube feedings. This failure posed likely harm to all residents' health. The findings include: 1. The facility's nursing services failed to ensure that each licensed staff had received training on procedures to accurately measure the clients' body weight. Resident #1 had a decrease in her body weight from 88.7 pounds in March 2009 to 62 pounds in April 2009. The client, as of September 29, 2009, had lost an additional pound, placing her below her Healthy Weight Range (HWR 62-82 lbs). On September 30, 2009, beginning at 8:45 p.m., interviews were conducted with the RN supervisor and Director of Nursing to ascertain more information. According to RN Supervisor, weight variations had been documented for several of the clients residing in the facility and it was suspected that weight's had not been completed and/or measured accurately in previous months. The RN supervisor further indicated that the weighing policy had been revised to ensure accuracy of weights and to identify measures to enact if warranted. The Director of Nursing (DON) revealed that the Supervisory nursing staff had provided training to the nursing staff on the correct policy and procedure for measuring clients' body weights, to include calibration of the scale to ensure that the scale was accurately measuring weight. Earlier interview with the LPN and the QMRP on September 30, 2009 revealed that a new scale, recommended by the Interdisciplinary Team (IDT) had been ordered, but had not been received.	{I 229}		

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(I 229)	Continued From page 6 The QMRP indicated that the scale currently being used in the facility had been calibrated and was accurate. The QMRP also indicated that all nurses had been trained in its use. When the LPN on duty was asked to demonstrate the weighting techniques, she failed to following the weighing protocol that required the scale to be calibrated prior to placing the individual on the scale. The QMRP acknowledged that the LPN failed to following the weighing protocol. The RN was asked to provide evidenced that all nurses had been trained to weigh clients using the chair scale. The RN could not provide any documentation of training. 2. Similarly, interview with the nurses indicated that the Supervisory RN and Director of Nursing had trained nursing staff on tube feeding procedures for Resident #1. This reportedly addressed changes in the client's tube feeding schedule. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on tube feeding procedures. No additional information was provided; therefore, a chronological history of nurse training on the facility's weighing and G-Tube feeding protocol could not be verified. It should be noted that this is a repeat deficiency. 3. Cross Refer to W331 (#1a.b.c). The facility failed to ensure nursing staff were effectively trained to transcribe physician's orders accurately. a. Review of Resident #1's record on September 30, 2009 evidenced physician orders (dated	(I 229)		

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(I 229)	Continued From page 7 September 1, 2009, and September 9, 2009, September 23, 2009 September 29, 2009) that were transcribed inaccurately, which could likely posed a risk to the residents' health and safety. According to the Director of Nursing (DON), the supervisory nursing staff had provided training to all nursing staff on and after the August 25, 2009, on the importance of transcribing physician orders' accurately. Review of the in-service training records, however, failed to show evidence of said training on transcribing of all physicians' orders. The DON acknowledged that the physician's orders were transcribed incorrectly and that nursing inservice training session were ineffective. 3. Cross-refer to W331.6 The facility's nursing services failed to ensure that each licensed staff had received training on procedures to properly calculate fluid restrictions for Resident #2 and #3, as ordered by the Primary Care Physician (PCP). Review of Resident #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Resident #2's physician orders verified the client was prescribed a fluid restriction of 880 cc of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e.	(I 229)		

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(I 229)	Continued From page 8 mealtime protocol) at approximately 3: 40 p.m. revealed the resident's total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Resident #3's physician ' s orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the client ' s total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on fluid intake/restrictions.	(I 229)		

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{I 291}	Continued From page 9	{I 291}		
{I 291}	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to ensure that all entries in residents' records were signed, for three of the six residents residing in the facility. (Residents #4, #5 and #6) The findings include: The GHMRP failed to ensure that physician's telephone orders were signed and dated within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13]. a. Review of Resident #5's records revealed a telephone orders dated September 29, 2009. According to the orders, the Resident was prescribed Debrox five drops to both ears, twice a day for five days. Further review of the telephone order revealed no evidence that the order was signed by the primary care physician (PCP). Interview with the registered nurse (RN) on October 7, 2009 at approximately 2:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. b. Review of Resident #4's medical records revealed a telephone orders dated September 19, 2009. The order read, "Cleanse scratch on the forehead with peroxide, apply Neosporin ointment every shift until healed." Further review of the telephone order revealed no evidence that the order was signed or dated by the primary care physician (PCP). Interview with the registered nurse (RN) on October 7, 2009 at approximately	{I 291}	3514.2 This Statute will be met as evidenced by: Reference responses to W104, W114, and W149, and W45C.	11.19.09 ongoing

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{I 291}	Continued From page 10 2:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. c. Review of Resident #4's medical record revealed a telephone orders dated October 8, 2009 at approximately 3:15 p.m. According to the orders, the resident was prescribed Fosamax 70 mg, one tab, by mouth, every week on Wednesday for osteoporosis. Further review of the telephone order revealed no evidence that the order was signed by the primary care physician (PCP). Interview with the registered nurse (RN) on October 8, 2009 at approximately 4:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. d. Review of Resident #4's medical record revealed a telephone orders dated October 10, 2009 at approximately 3:15 p.m. The order read discontinue 17 units Lantus subcutaneously (SQ) at bedtime for diabetes mellitus; Given Lantus 10 units SQ at bedtime for diabetes mellitus; and discontinue 1/2 diet pudding at bedtime; and give 4 ounces apple juice and one graham cracker. Further review of the telephone order revealed no evidence that the order was signed by the primary care physician (PCP). Interview with the registered nurse (RN) on October 8, 2009 at approximately 4:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. e. Review of Resident #4's physician orders sheet on October 7, 2009 at approximately 1:45 p.m., revealed several telephone orders that had been signed but not dated by the facility's PCP as documented below: - On September 9, 2009 at 6:00 p.m., the PCP ordered via telephone, an X-ray to last toes left	{I 291}		

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(I 291)	Continued From page 11 foot for toe discoloration; - On September 11, the podiatrist wrote an order for one pair of custom made shoes; and - On September 11, 2009, the podiatrist wrote an order to get pain medication from PCP in regards to pain 4th and 5th toes left foot. f. Review of Resident #6's physician orders sheet on October 8, 2009 at 3:45 p.m., revealed several telephone orders that had been signed but not dated by the facility's PCP as documented below: - On May 17, 2009 at 7:00 p.m., the PCP ordered via telephone, to discontinue Tylenol 650 mg PRN for temperature greater than 100. Start Tylenol 650 mg by mouth every four hours for pain or temperature greater than 100 degree Fahrenheit, PRN - On May 18, 2009 at 1:00 p.m., the PCP ordered via telephone, Augmentin 500 mg by mouth, twice a day for 15 days. Keep patient from picking left 3rd finger. Bactroban ointment to finger, three times a day until healed, clean with normal saline. --- Based on interview and record review, the facility failed to ensure that all entries in residents' records were signed, for one of the three clients included in the sample. (Resident #1) The findings include: Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 PM revealed Resident #1 had telephone orders that	(I 291)		

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(I 291)	Continued From page 12 had been signed but not dated by the facility's Primary Care Physician (PCP) as documented below: On August 31, 2009 at 5 p.m. the PCP ordered via telephone the client to return to her day program after an illness; On September 1, 2009 at 3 p.m. the PCP ordered via telephone to discontinue Peptamen DT @ 40 cc/hr x 10 hours from 7 p.m. until 5 a.m.; and On September 1, 2009 at 3 p.m. PCP ordered via telephone that the client Start Peptamen DT @ 50 cc 1 hour x 10 hours from 7 p.m. until 5 a.m. Interview with the Register Nurse on September 30, 2009 failed to provide an explanation as to why the physician had not dated the orders.	(I 291)		
(I 401)	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by; Based on observation, interview and record review, the Group Homes for Mentally Retarded Persons (GHMRP) failed to ensure nursing services in accordance with each resident's needs, for four of the six residents residing in the facility. (Residents #3, #4, #5, and #6) The findings include:	(I 401)	3520.3 **This Statute will be met as evidenced by:** 1. Reference response to W192 2. Reference response to W436 3. Reference responses to W192, W436 and 331.	11.26.09 ongoing

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(I 401)	Continued From page 13 October 1, 2009, the GHMRP was cited for failure to ensure employees providing nursing serves, were trained to competently transcribe orders, assess weights, calculate fluid restriction and administer G-tube feedings On October 13, 2009, the facility submitted a Plan of Correction (POC) which stated that all nurses in the home would receive additional training on appropriate transcribing of physicians' orders, adherence to the medication administration policy, documentation and communication between the primary care physician (PCP), ensure consistency with mealtime protocols in accordance to physician orders and addressing nutrition recommendations. 1. Cross Refer to W192. The GHMRP failed to ensure nursing staff were effectively trained to transcribe and review physician's orders accurately. (Resident #4 and resident #5) 2. Cross Refer to W436. The GHMRP nurses failed to follow-up on medical consultation order for custom molded shoes for Resident #4. 3. The GHMRP's medication nurse failed to use the appropriate adaptive feeding equipment during medication administration for Resident #5. During medication administration observation on October 14, 2009 at 9:15 p.m., the Licensed Practical Nurse (LPN) was observed administering Resident #5 her medications using a regular cup. The liquid was observed to spill from the resident's mouth. During dinner observations on October 14, 2009 at 5:35 p.m., the direct care staff was observed assisting the resident with drinking using a spout cup. Further observations revealed no spillage during the meal. Interview with the direct care staff on	(I 401)		

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(I 401)	Continued From page 14 October 14, 2009, during the meal revealed that the resident required a spout cup during feeding to reduce spillage. Review of the resident #5's feeding protocol dated April 22, 2009, verified the staff's interview by revealing the resident should be fed with an adaptive spout cup to reduce spillage. 4. During dinner observations on October 7, 2009 at 6:33 p.m., Resident #4 was observed eating. The meal consisted of shredded chicken, sliced carrots and rice. Interview with the direct care staff, during the meal, indicated that the resident receives a chopped texture diet. Review of Resident #4's mealtime protocol dated January 22, 2009, revealed a chopped texture diet. Further review of the resident's current physician orders dated October 2009, confirmed the mealtime protocol. Review of the facility's training records on October 8, 2009, at approximately 3:00 p.m., revealed that the staff received training on Resident #4's diet and feeding protocol on August 28, 2009. However the direct care staff failed to provide the proper diet consistency to Resident #4. --- Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with residents' needs, for three of three residents in the sample. (Resident #1, Resident #2 and Resident #3) The findings include:	(I 401)		

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{I 401}	Continued From page 15 1. The nursing staff failed to transcribe Resident #1's physician's orders accurately, which could likely pose a risk to the residents' health as evidence by the following: a. Interview with the nursing supervisor on September 30, 2009 at 8:45 a.m. revealed that Resident #1 was hospitalized from September 15, 2009 through September 23, 2009 for elevated temperature and PEG tube infection. Further interview revealed that the RN supervisor had contacted the Primary Care Physician (PCP) upon the resident's return to the group home and received an order to "resume all previous orders". Review of Resident #1's record at approximately 9:00 a.m. revealed a readmission order that indicated "orders valid for 120 days. Resuming all previous orders, T.O. (telephone order) PCP reviewed by RN supervisor 9/23/09." Additional handwritten orders, dated September 23, 2009 were discovered in the nurses' station by Licensed Practical Nurse (LPN) #1 that were more specific and identified discharge orders that were not signed by the transcriber or the physician. The Register Nurse (RN) stated that she received the telephone orders from the PCP between 4 p.m. and 5 p.m. and acknowledged that she had not transcribed the telephone order from the PCP when it was given to her. On 9/30/09 at approximately 3:30 p.m. contact was made with the PCP via phone which verified that he had given the RN supervisor a telephone order to resume all previous orders. At the time of the investigation, the facility's RN failed to transcribe telephone orders as given. b. Review of a physician order dated September 1, 2009 at approximately 8:55 am revealed the resident was to receive Dilantin chewable tablets	{I 401}		

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(I 401)	Continued From page 16 (U-D 50 mg tablets), 2 tablets crushed via G tube everyday at 7 a.m. for seizure disorder, hold tube feeding for 1 hour before and after administration of Phenytoin. Review of the corresponding Medication Administration Record at 9:00 a.m. revealed that the resident was receiving her G-tube feeding from 6 p.m. to 6 a.m. Review of the Medication Administration Record (MAR), however, revealed that the resident was being administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 AM. In an interview with the RN Supervisor at 9:05 a.m. , she acknowledge that Resident #1 was administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 a.m. c. Review of the Resident #1's records at approximately 10:45 a.m. revealed a physician order, dated September 1, 2009. According to the physician's order, the resident was prescribed Dilantin 2 tabs (100 mg) crushed via G-tube for seizure disorder. Review of the September 2009 MAR; however, documented the transcription of the order on September 29, 2009 as Dilantin (chewable)U-D 50 mg tab, 20 tablets (100 mg) crushed via G-tube for seizure disorder. The MAR was signed by a nurse on September 30, 2009 indicating the order for 20 tablets had been administered. Interview with the RN supervisor at approximately 10:45 a.m. acknowledge the order for 20 tablets of Dilantin crushed via G-tube for seizure disorder had been transcribed instead of Dilantin (chewable) U-D 50 mg tab, 2 tablets (100 mg) crushed via G-tube everyday . 2. The nursing staff failed to calculate Resident #1's G-Tube flushes in accordance with physician orders which could likely pose a risk to the residents' health and safety as evidence by:	(I 401)		

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(I 401)	Continued From page 17 Review of the Resident #1's medical record revealed a physician order, dated September 1, 2009. According to the order, the resident was to receive water flushes (via G-tube) prior to medications, between, and after medications. The order specified that her G-tube was to be flushed with 20 cc of water both prior to and after medications, and a 5 ml flush was to occur between medications. The review of the corresponding Fluid Intake Monitoring Sheet for G-Tube, dated September, 2009, revealed that the nurses documented completing 70 cc of water flushes, which did not correspond to the number of times medication was administered. The Director of Nursing (DON) could not explain the discrepancy. Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility nursing staff were completed the flushes incorrectly. 3. The nursing staff failed to clarify Resident #1's physician telephone orders accurately, which could likely pose a risk to the residents' health and safety as evidence by: a. Review of Resident #1's records revealed a telephone order, dated September 29, 2009. According to the resident's physician's telephone order, the resident was prescribed " Osmolyte 1.2 at 30 cc/hr, 1 can every 6 hours from 6 a.m. - 6 p.m. (total of 3 cans per day) with 2 packages of Procel a day or 909 kcals, 49 gm protein, 580 ml of water a day " . The nurse failed to clarify how to administer three cans of feedings with the restriction of one can every six hours during her 12 hour continuous feed. Furthermore, the nurse failed to identify the exact type and amount of Protein supplement to be administered with the	(I 401)		

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{I 401}	Continued From page 18 resident's continuous feed. It should be noted that interview with the Director of Nursing at approximately 5:30 p.m. acknowledged that three cans of the Osmolyte 1.2 could not be administered in total at the prescribed rate within the specified 12 hour feeding cycle. b. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the resident had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days. Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. 4. The facility nurses failed to administer Resident #1's prescribed G-tube feeding at scheduled time. On September 30, 2009 at approximately 6:00 p.m. Resident #1 was observed laying in her bed, at approximately a 30 degree angle and was not receiving her 6 p.m. continuos G-tube feeding. At approximately 6:15 p.m., the Department of Health surveyors informed the Director of Residential Services that Resident #1's prescribed feeding had not been administered at the prescribed time. At approximately 6:35 PM the LPN #2 was observed administering 2 cans Osmolite 1.2 cal at 30 cc/hr. 5. The facility nurses failed to update Resident #1's Health Management Care Plan (HMCP).	{I 401}		

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{I 401}	Continued From page 19 a. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 on September 30, 2009 revealed that the resident had "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:00 a.m. revealed Resident #1's HMCP did not updated to include the new diagnoses of Abscess/cellulitis-skin and postoperative infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:15 a.m. acknowledged that the HMCP had not been updated to include the September 9, 2009 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection. b. Review of the hospital discharge summary report dated September 22, 2009 revealed that Resident #1 was hospitalized from September 15, 2009 to September 23, 2009 for treatment of an elevated temperature and PEG tube infection. Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:05 a.m. revealed Resident #1's HMCP was not updated to include the treatment for elevated temperature and PEG tube infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:35 a.m. acknowledged that the HMCP had not been updated to include the hospitalization for elevated temperature and PEG tube infection.	{I 401}		

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(I 401)	Continued From page 20 There was no evidence that the HMCP had been updated since August 25, 2009. 6. The facility nurses failed to accurately implement Resident #2 and #3's fluid restriction. Review of Resident #2 and #3's Fluid Restriction Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #2 was prescribed a fluid restriction of 880 ' s cc of fluid daily. Review of Resident #2's physician orders verified the resident was prescribed a fluid restriction of 880 cc of fluid daily. Review of the documentation utilized by nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the resident's total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Resident #3's physician ' s orders,	(I 401)		

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(I 401)	Continued From page 21 verified that the resident was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the resident's total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. There was no evidence that fluid restriction requirements were implemented as prescribed.	(I 401)		
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis, for two of the six residents residing in the facility. (Resident #4 and #5) The findings include: 1. Review of Resident #4's medical record on October 7, 2009, at approximately 4:00 p.m., revealed an annual nursing assessment dated	I 407		

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I 407	Continued From page 22 January 17, 2009. Further review of the resident's record revealed there was no quarterly assessment in the record after the annual nursing assessment. Interview with the RN on October 7, 2009, at approximately 4:45 p.m., revealed that direct physical examinations should be completed every quarter (3 months). 2. Review of Resident #5's medical record on October 7, 2009, at approximately 7:00 p.m., revealed an annual nursing assessment dated September 27, 2009, however, the assessment was incomplete. The assessment had four of the seven pages completed. Interview with the RN on October 7, 2009, at approximately 5:00 p.m., confirmed the assessment was incomplete.	I 407		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to ensure residents received custom made shoes, for one of the six residents residing in the facility. (Resident #4) The finding includes: During observations during the survey, on October 7, 2009 and October 8, 2009, Resident #4 was observed kicking off her sneakers.	I 436	3521.7(f) This Statute will be met as evidenced by: Reference response to W436.	11/18/09 ongoing

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I 436	Continued From page 23 Interview with the direct care staff during the survey revealed that the resident does not like to keep her shoes on. Review of Resident #4's medical record on October 8, 2009, at 1:45 p.m., revealed a podiatry consult dated September 11, 2009. The consult indicated mild discolorations on the 4th and 5th left toes. A prescription was written for a pair of custom made shoes. Interview with the licensed practical nurse (LPN) #2 on October 8, 2009 at approximately 2:00 p.m. revealed that an appointment had not been scheduled nor was she aware of the physician order. After the interview, an appointment was scheduled for custom molded shoes.	I 436		
(I 473)	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to assure that all drugs are administered in compliance with the physician's orders, for three of six residents residing in the facility. (Residents #3, #4 and #6) The findings include: 1. The nursing staff failed to administer Resident #4's order as prescribed which posed a likely risk to the resident's health and safety. a. Observation of the evening medication administration on October 7, 2009 revealed	(I 473)	3522.4 This Statute will be met as evidenced by: Reference responses to W331, W368, W192, W381, W149, W455 and W104	11.18.09 onyon

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{I 473}	Continued From page 24 Resident #4 was administered Novolog Insulin 5 units at 6:45 p.m. (SQ given at 90 degree angle), Glucophage 1000 mg, and Os-Cal 200 mg. Review of the corresponding Medication Administration Record and October 2009 physicians orders on October 7, 2009, revealed the Resident was prescribed Novolog insulin 5 units before dinner on October 7, 2009. A face to face interview with LPN #1on October 7, 2009 immediately following the medication observation revealed that she gave Novolog insulin 4 units previously ordered on February 20, 2009. When LPN#1 was asked by the surveyor why she did not give the 5 units as ordered, she stated " I was not aware of the new order". Further observation on October 7, 2009 at approximately 6:00 p.m. revealed the nurse changed on the MAR to indicate that Novolog insulin 5 units would start on October 8, 2009 and not on October 7, 2009 as ordered by the physician. There was no documented evidence in the record that the nurse made the physician aware that the order did not start on October 7, 2009 as prescribed. b. Review of Resident #4's record on October 8, 2009 at approximately 11:00 a.m. revealed a telephone order dated July 21, 2009, at 4:20 p.m. The order the resident was to receive which documented, "Debrox ear drops 6.5% 5 drops to both ears twice daily for five days (which should equal to 10 doses of medication) for wax removal." Further review of resident #4's record revealed a MAR for July 2009 that documented that the GHMRP's nursing staff failed to administer all ten	{I 473}		

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	HFD03-0035	A. BUILDING _____ B. WING _____	R 10/16/2009

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(I 473)	Continued From page 25 doses of Debrox as ordered. According to the record, Resident #4 received nine of the ten doses ordered. c. A record of Resident #4's record on October 8, 2009, at approximately 11:30 a.m. revealed a telephone order for Debrox dated August 4, 2009 at 4:30 p.m. According to the order, the resident was to receive "Debrox optic drops 6.5% instill 4 drops in left ear twice a day for 5 days (which should equal to 10 doses of medication)." Further review of record revealed a MAR for August 2009 which documented that the GHMRP nursing staff failed to administer the ten doses of Debrox ordered. Resident #4 received nine of the ten doses ordered. d. Review of Resident #4's record on October 8, 2009,at approximately 3:00 p.m. revealed an order date January 30, 2009 for "Head and Shoulders daily." Further review of Resident #4's record revealed MAR's from February 2009 through October 2009 which documented that Resident #4 had treatments of the Head and Shoulders three times a week (which was an ordered dated from February 23, 2004). During a face to face interview with LPN#2 on October 8, 2009, at approximately 4:55 p.m. revealed that Resident #4 had a dermatology consult in January 2009 however, she was unable to locate the report at the time of the interview. She acknowledged that Resident #4 was not receiving the Head and Shoulder treatments daily as prescribed. 2. During the entrance conference on October	(I 473)		

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{I 473}	Continued From page 26 14, 2009, at 1:33 p.m., the registered nurse (RN) indicated that Resident #3 received a new physician order for eye drops. Review of Resident #3's medical records on October 14, 2009 at 2:30 p.m. revealed a telephone order for Gentamicin eye drops, four times a day to both eyes, dated October 7, 2009 at 5:00 p.m. According to the MAR, the Resident received Gentamicin (generic eye drops) sulfate 30 mg/ml, two drops in each eye twice a day, beginning October 9, 2009 through October 14, 2009. Interview with the RN on October 14, 2009 at approximately 3:00 p.m., confirmed the Resident received two eye drops twice a day. There was no evidence that the facility's medication nurse administered Resident #3's eye drops as ordered (four times a day). 3. Review of Resident #6's medical record on October 8, 2009, at 4:15 p.m., revealed a telephone order dated May 18, 2009. The order was for Augmentin 500 mg by mouth, twice a day for 15 days (30 doses). Review of the Resident's medication administration records (MARs) on October 8, 2009 at approximately 4:30 p.m. revealed that the Resident received the medication beginning on May 18, 2009, during the evening medication administration through May 31, 2009. Further review of the MAR's revealed that the Resident received 27 doses of the prescribed medication. Additionally the registered nurse (RN) was interviewed on October 8, 2009 at approximately 5:10 p.m., to ascertain information regarding the location of the June 2009 MAR. The RN could did not retrieve the June 2009 MARs. By the end of the survey, the RN failed to locate and provide the June 2009 MAR for review.	{I 473}		

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{I 473}	Continued From page 27 There was no evidence that Resident #6 received the prescribed doses of the antibiotics. Based on interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for one of three residents included in the sample. (Resident # 1) The finding includes: 1. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated August 25, 2009 at 12 noon revealed that she was diagnosed with a Furuncle (boil). Further review of the medical record revealed a physician order, dated August 25, 2009. According to the physician ' s order, Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day for 7 days (for upper lip abscess). Although the medication was prescribed for 7 days, the August 2009 MAR indicated that Bactrim OS Suspension 20 ml was initially administered on August 26, 2009 at a.m. and discontinued on September 2, 2009 at 7 p.m. (8 days). Interview with the RN Supervisor at approximately 12:15 p.m. acknowledged that Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day. Additionally, the RN verified that the medication had been administered for 8 days. 2. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the Resident had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and	{I 473}		

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{I 473}	Continued From page 28 Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended "Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days." Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. Review of September 2009 MAR on September 30, 2009 at approximately at 1:00 PM revealed Keflex 250 mg (5 ml suspension) 10 ml Q 6 hours x 10 days was not documented as administered on September 13, 2009 at 6 p.m. Interview with the RN Supervisor at approximately 1:15 p.m. acknowledged that Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs was not documented as administered. Based on interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to assure that all drugs are administered in compliance with the physician's orders, for three of six residents residing in the facility. (Residents #3, #4 and #6) The findings include: 1. On October 14, 2009, at 1:33 p.m., the registered nurse (RN) indicated that Resident #3 received a new physician order for eye drops. Review of Resident #3's medical records	{I 473}		

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{I 473}	Continued From page 29 revealed a telephone order for Gentamicin eye drops, four times a day to both eyes, dated October 7, 2009 at 5:00 p.m., on October 14, 2009, at 2:30 p.m. According to the medication administration records (MARs), the client received Gentamicin (generic eye drops) sulfate 30 mg/ml two drops in each eye twice a day, beginning October 9, 2009 through October 14, 2009. Interview with the RN on October 14, 2009 at approximately 3:00 p.m., confirmed the resident received two eye drops twice a day. There was no evidence that the facility's medication nurse administered Resident #3's eye drops as ordered (four times a day). 2. The nursing staff failed to administer order as prescribed for Resident #4, which posed a potential risk to the client's health and safety. a. A review of Resident #4's record revealed an order dated October 7, 2009 which ordered Novolog insulin 5 units before dinner at 5:30 p.m. A face to face interview with LPN #1 revealed that she gave Novolog insulin 4 units as previously ordered on February 20, 2009 and a Medication Administration Record for the month October 2009 which reflected the new order of Novolog insulin 5 units before dinner to start at 5:30 p.m. on October 7, 2009. When LPN#1 was asked by the surveyor why she did not give the 5 units as ordered. She stated " I was not aware of the new order ". Further observation on October 7, 2009 at approximately 6:00 p.m. revealed the nurse documenting on the MAR for the Novolog insulin 5 units before dinner to start on October 8, 2009 and not on October 7, 2009 as ordered by the physician.	{I 473}		

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{I 473}	Continued From page 30 There was no documented evidence in the record that the nurse made the physician aware of the order not starting on October 7, 2009 as prescribed. b. A record review October 8, 2009 of Resident #4's record at approximately 11:00 a.m. revealed a telephone dated a telephone ordered dated July 21, 2009 at 4:20 p.m. which ordered, " Debrox ear drops 6.5% 5 drops to both ears twice daily for five days (which should equal to 10 doses of medication) for wax removal." Further review of the record revealed a MAR for July 2009 which documented that the facility nursing staff failed to administer all ten doses of Debrox as ordered. Resident #1 received nine of the ten doses ordered. c. A record review on October 8, 2009 of Resident #4's record at approximately 11:30 a.m. revealed a second telephone order for Debrox dated August 4, 2009 at 4:30 p.m. order read "Debrox optic drops 6.5% instill 4 drops in left ear twice a day for 5 days (which should equal to 10 doses of medication)." Further review of record revealed a MAR for August 2009 which documented that the facility nursing staff failed to administer the ten doses of Debrox ordered. Resident #1 received nine of the ten doses ordered. d. A record review on October 8, 2009 of Resident #4's record at approximately 3:00 p.m. revealed an order date January 30, 2009 for "Head and Shoulders daily."	{I 473}		

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(I 473)	Continued From page 31 There was no documented evidence that Resident #4 received treatment of Head and Shoulders daily. Further review on the record revealed MAR's from February 2009 through October 2009 which documented that Resident #4 had treatments of the Head and Shoulders three times a week (which was an ordered dated from February 23, 2004). During a face to face interview on October 8, 2009 at approximately 4:55 p.m. with LPN #2, she revealed that Resident #4 had dermatology consult in January 2009 however she was unable to locate the report at the time of this interview. She acknowledged the finding. 3. Review of Resident #6's medical record on October 8, 2009 at 4:15 p.m. revealed a telephone order dated May 18, 2009. The order was Augmentin 500 mg by mouth, twice a day for 15 days. Review of the resident's medication administration records (MARs) on October 8, 2009 at approximately 4:30 p.m. revealed that resident received the medication beginning on May 18, 2009 during the evening medication administration through May 31, 2009. Further review of the MARs revealed that the resident received 27 doses of the prescribed medication. Inquiry was made with the registered nurse (RN) on October 8, 2009 at approximately 5:10 p.m., of the June 2009 MARs were. The RN could did not retrieve the June 2009 MARs. By the end of the survey, the June 2009 MARs were not available for review. There was no evidence that Resident #6 received the prescribed doses of the antibiotics.	(I 473)		

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